DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES
POLICIES AND PROCEDURES

Section:	Community Policy Management Section	**Effective Date:**	1/1/2011
Team:	LME Team	**Policy No.**	LME 102
Subject:	Endorsement Policy	**Revision date :**	4/15/2011
Approved By:		**Approval Date:**	4/15/11

PURPOSE:

The purpose of the endorsement policy is to establish a statewide system for assuring that providers of mental health, developmental disabilities and substance abuse (mh/dd/sa) services meet qualifications required to be eligible to receive Medicaid funding. This system ensures that individuals receive services and supports from providers that comply with state and federal laws, rules, regulations, quality standards and policies.

SCOPE:

This policy applies to all providers of Medicaid-reimbursable mh/dd/sa services who are required by the North Carolina State Plan for Medical Assistance under Title XIX of the Social Security Act (NC State Plan) to be endorsed prior to enrollment in the NC Medicaid program including hospitals and academic institutions. This policy does not apply to an LME with a Centers for Medicare and Medicaid Services (CMS) approved waiver.

Pursuant to 10A NCAC Subchapter 22P, a provider seeking to provide Intensive In-Home, Child and Adolescent Day Treatment, Community Support Team, Peer Supports, or Targeted Case Management Services for mh/sa consumers must also be certified as a Critical Access Behavioral Health Agency.

POLICY STATEMENT:

The North Carolina Department of Health and Human Services (DHHS) requires that all providers requesting enrollment in the NC Medicaid Program to provide mh/dd/sa services must be assessed prior to enrollment to ensure that they meet objective criteria, including compliance with all state and federal laws, rules, and regulations, and have the capacity to sustain quality service delivery. Endorsement is intended to ensure that a provider meets qualification requirements prior to the initiation of service delivery. Continued provider compliance with all state and federal laws, rules, regulations and DHHS policies, guidelines, Medicaid bulletins and Implementation Updates is reviewed on an ongoing basis through announced and unannounced monitoring visits, licensure activities, and audits conducted by NC DHHS, its Divisions and contractors.

ENFORCEMENT:

The DMH/DD/SAS Local Management Entity (LME) Team is responsible for interpretation and enforcement of this policy.

EXCEPTIONS:

This policy does not apply to an LME with a Centers for Medicare and Medicaid (CMS) waiver.

DEFINITIONS:

As used in this policy the following terms have the meanings specified:

(1) **"Business Entity"** means any domestic or foreign corporation, nonprofit corporation, professional corporation, limited liability company, profit and nonprofit unincorporated association, business trust, partnership or two or more persons having a joint or common economic interest. The business headquarters may be in a different physical location than the site location seeking site/service specific endorsement.

(2) **"Business Entity Verification"** means to confirm the completeness and accuracy of the business entity information as required on the application.

(3) **"Catchment area"** means the geographic part of the State served by a specific area authority or county program or LME.

(4) **"Check Sheet"** means the list of requirements, per each service definition, that shall be met in order to obtain endorsement (check sheets are available on the DMH/DD/SAS website at http://www.ncdhhs.gov/mhddsas).

(5) **"The Community Alternatives Program for Persons with Mental Retardation/ Developmental Disabilities (CAP-MR/DD)" -** a Medicaid waiver program to serve individuals who would otherwise require care in an intermediate care facility for people with mental retardation/developmental disabilities (ICF/MR). It waives the person's right to receive Medicaid funded ICF/MR services and instead allows these individuals the opportunity to be served in the community.

(6) **"Community Intervention Services (CIS) Agency"** – means a provider agency classification confirming that the agency has met the eligibility criteria for entering into a participation agreement with the Division of Medical Assistance (DMA) to provide certain specific services that have been endorsed or approved by the LME, or the DMH/DD/SAS in the case of an LME, responsible for determining such eligibility. Once approval or endorsement has been awarded, the provider is approved as a Medicaid Provider of Community Intervention Services and enters into a participation agreement with the DMA to provide the services.

(7) **"Core Rules"** means those general rules identified in Rules 10A NCAC 27G .0100-.0900,

governing mh/dd/sa services, for both facilities and agencies providing such services, and the Local Management Entities administering such services within the scope of N.C.G.S. §122C.

(8) **"Critical Access Behavioral Health Agency" (CABHA)** means a Critical Access Behavioral Health Agency certified pursuant to 10A NCAC Subchapter 22P.

(9) **"Endorsement"** means a verification and quality assurance process using statewide criteria and tools set out in this Policy to determine the competency and quality of a provider of mh/dd/sa services.

(10) **"Endorsing Agency"** means the entity, whether it is the Local Management Entity or DMH/DD/SAS, which has the statutory responsibility to endorse and/or withdraw endorsement of a provider organization for the provision of a service.

(11) "**Good Standing – DHHS"** means the same as defined in 10A NCAC 22P.0402.

(12) **"Good Standing – LME"** means the provider has a history of compliance with DMA Clinical Policy specific to service delivery and does not have an open Plan Of Correction (POC) with the LME. A POC must be timely submitted, approved, and implemented before the POC action can be closed. A POC is fully implemented when the POC is being followed and all out of compliance findings have been minimized or eliminated as determined by the LME in a maximum of two follow-up reviews. The POC action is closed when the provider receives the official notification from the LME stating the action is closed.

(13) **"Legally Constituted Entity"** means a corporation or domestic corporation as defined in G.S. 55-1-40(4), a foreign corporation as defined in G.S. 55-1-40(10), a foreign limited liability company as defined in G.S. 57C-1-03(8), a foreign limited liability limited partnership as defined in G.S. 59-102(4c), a foreign limited liability partnership as defined in G.S. 59-32(4g), a foreign limited partnership as defined in G.S. 59-102(5), a foreign nonprofit corporation as defined in G.S. 55A-1-40(10c), a limited liability company or domestic limited liability company as defined in G.S. 57C-1-03(11), a limited liability limited partnership as defined in G.S. 59-102(6a), a limited liability partnership or registered limited liability partnership as defined in G.S. 59-32(7), a limited partnership or domestic limited partnership as defined in G.S. 59-102(8), a nonprofit corporation or domestic nonprofit corporation as defined in G.S. 55A-1-40(5), or an individual as defined in G.S. 55-1-40(13), or a business entity that is not registered with the North Carolina Secretary of State but is registered with the local municipality.

(14) **"Local Management Entity" or "LME"** means the same as defined in N.C.G.S. §122C-3(20b).

(15) **"Notification of Endorsement Action" or "NEA"** means the state approved standardized document which notifies the provider of the status of its endorsement.

(16) **"Provider"** means the legally constituted entity seeking endorsement to provide the service; this also includes the corporate parent of such legally constituted entity.

(17) **"Record(s)"** means the clinical service record (also known as the medical record or service record) and personnel records.

(18) **"Resolved"** means the agency responsible for the regulation and oversight of the provider (i.e. LME, DHHS) is in receipt of a Final Agency or court decision or other documents showing that the outstanding or unresolved action has been closed and all implementation and follow-up reviews have been completed.

(19) **"Site" or "Site Location"** means the location where a service occurs or supervision occurs and records are kept. Service sites must adhere to all state and federal privacy regulations. Individuals, other than those receiving residential services, cannot receive services in the private residence of a provider agency's employee(s) or at a business site that provides services that are not regulated by DHHS, its Divisions or a Local Management Entity. In addition, the site cannot be a licensed residential facility of six beds or less unless the agency is only providing residential services.

(20) **"Site/Service Endorsement"** means the review and approval of a site location to provide a mh/dd/sa service or services to be delivered at or from the specific site location.

(21) **"Standard Agreement"** means the document approved by DHHS for statewide use which sets forth the expectations and responsibilities of the provider organization and the endorsing agency and has been signed by the parties. It is effective for a three year period and is also referred to as a Memorandum of Agreement (MOA).

(22) **"Substantial Failure to Comply"** means as defined in 10A NCAC 26C .0502.

PROCEDURE:

1. Business Entity Verification

Endorsement consists of two parts: business entity verification and site/service endorsement.

Business entity verification must take place prior to site/service endorsement. The provider shall submit to the endorsing agency, in whose catchment area the corporate office or the statewide headquarters is located, a correct and complete DMA Provider Enrollment Application with supporting documentation. The business entity verification shall be conducted by only one endorsing agency. The provider shall also submit to the endorsing agency documentation that the business entity is currently registered with the local municipality or the office of the NC Department of the Secretary of State, that the information registered with the local municipality or the Secretary of State is current and that there are no dissolution, revocation or revenue suspension findings currently attached to the provider entity. The provider agency must be a legally constituted entity. In addition, the provider shall submit documentation that the business entity is in good standing with the U.S. and the N.C. Department of Revenue. The provider is **only** required to submit evidence of good standing with the U.S. and the N.C. Department of Revenue at the time of the initial business verification review and the business entity verification renewal. The provider is not required to submit evidence of good standing with the U.S. or the N.C. Department of Revenue when applying for service endorsement or service re-endorsement.

The provider shall also submit service related documents (i.e., program description, job description, program schedule, etc.) in the event the provider chooses to seek site/service endorsement in the same

catchment area in which the provider is seeking business entity verification. Documents related to service delivery shall be reviewed by the endorsing agency at the desk review.

Where applicable, the provider shall also submit a completed Core Rules Self-Study (i.e., checklists) along with supporting documentation. The business entity shall comply with Rule 10A NCAC 27G .0201, Governing Body Policies. This packet shall serve as the application for endorsement with the endorsing agency.

The self-study is **not** required if:

(a) The business entity is accredited by an accrediting agency, approved by the Secretary of DHHS, such as the Council on Accreditation (COA), the Council on Quality and Leadership (CQL), the Council on Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission; or
(b) At least one mh/dd/sa service offered by the provider is provided in a facility licensed in accordance with N.C.G.S. § 122C; or
(c) At least one of the services already offered by the provider is provided in a facility licensed under N.C.G.S. § 131D and an endorsing agency has conducted a review within the last twelve months and determined the provider is in compliance with the requirements of the core rules; or
(d) The endorsing agency or a contract agency of the endorsing agency, or a like entity, has conducted a review within the last 12 months and determined the provider is in compliance with the requirements of the core rules.

Upon receipt of the application for endorsement, the endorsing agency shall review and verify the submitted information against any and all public databases, including businesses registered with the local municipalities and/or the list of corporations registered with the North Carolina Secretary of State as corporations and shall verify the name, business status and address of the provider. The endorsing agency shall evaluate the core rules self-study checklists and supporting documents, where applicable, for correctness and completeness. In addition, the endorsing agency shall also check with DHHS and/or other LMEs concerning violations by and actions against the provider to ensure that the provider is in good standing with DHHS and/or other LMEs. If prior to granting business entity verification it is determined that the provider agency is not in good standing with DHHS and/or any LME, the endorsing agency shall terminate the business entity verification process. The notice to the provider of the termination of the business entity verification process shall include a statement of the provider's appeal rights at the local and state level. The provider may reapply at any time after good standing with DHHS and/or the LME(s) has been re-established. If the provider organization determines that it will re-apply, the provider organization must initiate the process by submitting the complete application to the endorsing agency.

The endorsing agency shall notify the provider regarding the status of the business entity verification review via trackable mail within 20 calendar days following the receipt of the endorsement application. If additional information is needed to complete the business verification process, the provider will have 10 calendar days from the date of the notice requesting additional information to submit those materials to the endorsing agency. The additional materials must be submitted via trackable mail, electronically or hand delivery with signature confirmation. It is the responsibility of the provider to maintain documentation evidencing that the 10 calendar day timeline was met.

If the 10 calendar day timeline is met, the endorsing agency shall evaluate the materials and notify the provider via trackable mail within 10 calendar days of the receipt of the additional information regarding the status of the business entity verification review. If the required additional material is not received within the 10 calendar day timeline, the endorsing agency shall notify the provider via trackable mail that the information was not timely received and that the business entity verification is denied.

The business verification notification (NEA) letter shall specify one of the following actions:

(a) Provider meets business entity verification requirements and business entity verification is granted; or
(b) Provider does not meet business entity verification requirements and business entity verification is denied; the notice of denial shall include a statement of the provider's appeal rights at the local and state level.

2. Service Endorsement

Service endorsement is site and service specific. The provider must successfully complete three steps in order to achieve site/service endorsement:

(a) Desk Review of documents related to service specific check sheets
(b) Clinical Interview
(c) Onsite Review

2A. Desk Review

The endorsing agency shall perform a desk review of each service the provider seeks to provide within 20 calendar days from the date the endorsing agency sends notification that the provider organization meets business entity verification requirements. If additional information is needed to complete the desk review process, the provider will have 10 calendar days from the date of the notice requesting additional information to submit those materials to the endorsing agency. The additional materials must be submitted via trackable mail, electronically or hand delivery with signature confirmation. It is the responsibility of the provider to maintain documentation evidencing that the 10 calendar day timeline was met. If the 10 calendar day timeline is met, the endorsing agency shall evaluate the materials and notify the provider via trackable mail within 10 calendar days of the receipt of the additional information regarding the status of the desk review portion of the service endorsement process. If the required information is not received within the 10 calendar day timeline, the endorsing agency shall notify the provider via trackable mail that the information was not timely received and that the endorsement is denied.

In the event the provider has been granted business entity verification but chooses **not** to provide a service in the catchment area in which the business entity verification was granted, the provider shall submit an application for service endorsement to the endorsing agency where the service/site will be located. Documents related to the service(s) the provider seeks to deliver (i.e., program description, job description, program schedules, etc.) shall be submitted with the application for endorsement. The endorsing agency shall perform a desk review of each service the provider seeks to provide within 20 calendar days of the receipt of the provider's application. If additional information is needed to complete the desk review process, the provider will have 10 calendar days from the date of the notice requesting

additional information to submit those materials to the endorsing agency. The additional materials must be submitted via trackable mail, electronically or hand delivery with signature confirmation. It is the responsibility of the provider to maintain documentation evidencing that the 10 calendar day timeline was met. If the 10 calendar day timeline is met, the endorsing agency shall evaluate the materials and notify the provider via trackable mail within 10 calendar days of the receipt of the additional information regarding the status of the desk review portion of the service endorsement process. If the required information is not received within the 10 calendar day timeline, the endorsing agency shall notify the provider via trackable mail that the information was not timely received and that the endorsement is denied.

Providers who want to pursue CABHA certification using Community Support Team (CST), Intensive In-home (IIH) or Day Treatment (DT) as one or both of the services to create the age and disability specific continuum of the CABHA, shall submit a CABHA attestation letter to DMH/DD/SAS prior to submitting an endorsement application for these services to the endorsing agency. DMH/DD/SAS will complete a CABHA desk review (with the exception of the endorsement). Once the provider successfully completes the CABHA desk review (with the exception of the endorsement), the provider may then submit an endorsement application for CST, IIH, or DT to the endorsing agency. The requirement that the provider be serving consumers within 60 calendar days from the date of the DMA service enrollment letter as well as the requirement that the endorsing agency involuntarily withdraw endorsement if the provider does not serve consumers during any 120 day time frame does not apply until after the provider achieves CABHA certification. The 60 calendar time frame and the 120 consecutive day time frame shall begin from the date of the DMA CABHA enrollment letter. In the event the provider is endorsed for CST, IIH or DT but does not achieve CABHA certification, the endorsement will be involuntarily withdrawn effective the date of the final agency decision to deny the CABHA certification.

If a provider that has not been granted CABHA certification but applies for endorsement for one or all of the services (CST, IIH, DT) before submitting the CABHA attestation letter and packet to DMH/DD/SAS, the LME shall return the application and instruct the provider to reapply for endorsement once the CABHA desk review (with the exception of the endorsement) has been completed by DMH/DD/SAS.

The endorsing agency shall use the standardized NC DHHS – DMH/DD/SAS Endorsement Check Sheets to complete the desk review. The standardized check sheets can be found at www.ncdhhs.gov/mhddsas.

The desk review shall include a review of documents related to:

(a) Business Entity Verification requirements
(b) Staffing requirements
(c) Policy and Procedure Manual
(d) Personnel Manual
(e) Job descriptions
(f) Service type/setting requirements
(g) Program description
(h) Clinical requirements
(i) Documentation requirements

In all situations where the provider has not previously provided the service(s) and, therefore, has no completed consumer records the endorsing agency shall complete the desk review using the check sheets excluding those items requiring components of consumer records.

If at any time during the endorsement process it is determined that the provider agency is not in good standing with DHHS and/or any LME, the endorsing agency shall terminate the endorsement process. The notice to the provider of the termination of the service endorsement process shall include a statement of the provider's appeal rights at the local and state level. The provider may reapply at any time after good standing with DHHS and/or LME(s) has been re-established. If the provider organization determines that it will re-apply, the provider organization must initiate the endorsement process by submitting the complete endorsement application to the endorsing agency.

The endorsing agency shall notify the provider of the status of the desk review portion of the endorsement review within 10 calendar days following the completion of the desk review. The notification letter shall specify one of the following actions:

(a) Provider meets desk review requirements and the clinical interview is scheduled; or
(b) Provider is not in compliance with the requirements to provide the service(s) for which application was made and site/service endorsement is denied.

The notice of denial shall include a statement of the provider's appeal rights at the local and state level.

Currently enrolled and active DHHS Community Intervention Services (CIS) and CAP-MR/DD providers who wish to add a service to the existing location must first complete the CIS or CAP-MR/DD Addendum form and submit the completed form to the endorsing agency. Applications submitted to add a service shall not be processed if the provider is not in good standing with DHHS and/or any LME.

2B. Clinical Interview

The endorsing agency shall complete the clinical interview within 20 calendar days of the notification of the completion of a successful desk review.

The purpose of the clinical interview is to determine the clinical expertise and skill level of the provider's staff as well as their knowledge and understanding of the age and disability (i.e., mh/dd/sa) characteristics of the individuals they seek to serve. The provider shall hire all staff members to meet the staffing requirements of the service definition for which the provider is seeking to become endorsed by the date of the clinical interview. Prior to the clinical interview, the endorsing agency staff shall review the qualifications of the staff members hired to meet the staffing requirements of the service definition. If any staff person hired to meet the staffing requirements of the service definition does not meet the requirements for the position, then the clinical interview must be canceled and endorsement denied.

The clinical interview shall be conducted by at least two staff of the endorsing agency. For services that require a licensed professional as part of the staffing requirement, at least one of the endorsing agency's staff conducting the clinical interview shall be a licensed clinician (as defined in Rule 10A NCAC 27G.0104) and the other a qualified professional (as defined in Rule 10A NCAC 27G.0104). In the event the staffing requirement of the service does not include a licensed professional, the clinical interview may be conducted by two qualified professionals (as defined in Rule 10A NCAC 27G.0104) of the endorsing

agency. In both instances, at least one of the endorsing agency's staff conducting the clinical interview shall have knowledge and understanding of the age and disability characteristics of the individuals the provider agency is seeking to serve. An MD or PhD from the endorsing agency shall be present if the provider representative being interviewed is an MD or PhD. The clinical interview may, at the sole discretion of the endorsing agency, occur at the provider site/office or the endorsing agency office. The Clinical Director of the endorsing agency shall not be included in the team of two endorsing agency staff completing the clinical interview as the Clinical Director may be involved in the appeal process at the local level.

All provider staff hired to meet the staffing requirements of the service definition shall participate in the clinical interview unless otherwise noted in the standardized endorsement check sheet and instructions. The provider staff shall be asked questions from a checklist of standardized clinical questions. The standardized clinical questions check sheets can be found at www.ncdhhs.gov/mhddsas. At the sole discretion of the endorsing agency, the interview team may ask additional questions not identified on the check sheets during the interview to clarify a response made by the provider agency staff or otherwise determine the clinical expertise and skill level of the provider's staff as well as their knowledge and understanding of the age and disability (i.e. mh/dd/sa) characteristics of the individuals they seek to serve.

The endorsing agency staff that conducted the clinical interview shall make the decision regarding the provider's qualifications and readiness to provide the service(s) requesting endorsement by rating the clinical interview requirement as met or not met pursuant to the *Endorsement Clinical Interview Guidelines*. The *Endorsement Clinical Interview Guidelines* can be found at www.ncdhhs.gov/mhddsas.

If at any time during the endorsement process it is determined that the provider agency is not in good standing with DHHS and/or any LME, the endorsing agency shall terminate the endorsement process. The provider may reapply at any time after good standing with DHHS and/or LME(s) has been re-established. If the provider organization determines that it will re-apply, the provider organization must initiate the endorsement process by submitting the complete endorsement application to the endorsing agency.

The endorsing agency shall notify the provider within 10 calendar days following the clinical interview regarding the status of the clinical interview portion of the endorsement review. The notification letter shall specify one of the following actions:

(a) Provider meets the clinical interview requirements and the onsite review is scheduled; or
(b) Provider does not meet the clinical interview requirements and endorsement is denied.

The notice of denial shall include a statement of the provider's appeal rights at the local and state level. Upon request for reconsideration at the local level, the Clinical Director, or appointed designee, of the endorsing agency shall review the request for reconsideration.

2C. Onsite Review

The onsite review shall be completed within 20 calendar days of the notification of the completion of a successful clinical interview. The onsite review shall include a review of each service the provider seeks to provide, at each site where the provider seeks to provide a service.

The endorsing agency shall use the standardized endorsement check sheets during the onsite review to **verify** the documentation reviewed during the desk review as well as the sources of evidence indicated on the standardized NC DHHS-DMH/DD/SAS check sheet related to:

(a) Business entity verification requirements
(b) Staffing requirements, including staff names, qualifications, and positions
(c) Service type/setting requirements
(d) Clinical requirements
(e) Documentation requirements

In all situations where the provider has not previously provided the service(s) and therefore has no completed consumer records, the endorsing agency shall complete the onsite review using the check sheets excluding those items requiring components of consumer records.

If at any time during the endorsement process it is determined that the provider agency is not in good standing with DHHS and/or any LME, the endorsing agency shall terminate the endorsement process. The notice to the provider of the termination of the service endorsement process shall include a statement of the provider's appeal rights at the local and state level. The provider may reapply at any time after good standing with DHHS and/or LME(s) has been re-established. If the provider organization determines that it will re-apply, the provider organization must initiate the endorsement process by submitting the complete endorsement application to the endorsing agency.

The endorsing agency shall notify the provider regarding the status of the onsite review portion of the endorsement process within 10 calendar days following the onsite review. The notification letter shall indicate the following:

(a) Provider meets the onsite review requirements and endorsement is granted; the Standard Agreement shall be sent to provider for signature; or
(b) Site/service endorsement is denied on the basis that the provider is not in compliance with the requirements to provide the service(s) for which application was made.

Where site/service endorsement is denied, the notice shall include a statement of the provider's appeal rights at the local and state level.

The endorsing agency shall only grant the provider organization site/service endorsement once it has been determined that the provider organization has successfully met the desk review, clinical interview and onsite review requirements.

3. 60 Day Follow-up Review

The provider shall notify the endorsing agency, via trackable mail, of its receipt of the DMA enrollment letter within 10 calendar days from the date of the DMA enrollment letter. The endorsing agency shall monitor the provider's endorsed site within 60 calendar days from the date of the DMA enrollment letter. This monitoring shall include a review of compliance with the service definitions and sources of evidence indicated on the standardized NC DHHS – DMH/DD/SAS Endorsement Check Sheets.

The 60 day follow-up review shall include **but not be limited to** a review of documents related to the following elements:

(a) Provider requirements: provider staff training on DHHS and LME requirements for appropriate documentation, forms, prior authorizations, and continued insurance coverage per the Standard Agreement;
(b) Staff requirements: complete listing of all staff names, qualifications, and positions (note that all staff required for a service per the service definition are required to be employed and providing the service) to ensure staff are fully trained on the goals and objectives of the service and the strategies and techniques used, Medicaid RA Forms, Paid claims, ensure staff meet training requirements per definition;
(c) Service type/setting requirements: review service notes to ensure services provided are medically necessary and appropriate to consumer's needs based on diagnosis, person centered plan, Medicaid RAs, etc.;
(d) Clinical requirements: clinical reviews, staff supervision provided, staff interviews; and
(e) Documentation requirements: compliance with Basic Medicaid Billing guide and Medicaid provider enrollment agreement; all documentation must support the legitimacy of billing including a review of paid claims to determine if billing supported by service notes.

Providers are required to be serving consumers within 60 calendar days from the date of the DMA enrollment letter. If a provider has not accepted consumers and delivered services to consumers within 60 calendar days from the date of the DMA enrollment letter, endorsement shall be involuntarily withdrawn. In addition, if no consumers are served during any consecutive 120 day period, the provider's endorsement shall be involuntarily withdrawn by the endorsing agency.

4. Provider Failure to Meet Business Entity Verification and/or Service Endorsement Requirements

If a provider fails to meet business entity verification requirements, business entity verification shall be denied and the endorsing agency shall notify the provider, via trackable mail, of the basis for the failure to meet requirements; a copy of the denial letter shall be sent to the DMH/DD/SAS. The provider must wait 6 months before re-applying for business entity verification with **any** endorsing agency. The notice shall include a statement of the provider's appeal rights at the local and state level.

A provider that achieves business entity verification but fails to meet site/service specific requirements must wait 6 months to re-apply for that service with that specific endorsing agency. The provider may, however, apply for site/service endorsement through another endorsing agency at any time. The provider may also apply for **other** services through the LME where it failed to meet the specific site/service endorsement. If the provider organization determines that it will re-apply, the provider organization must initiate the endorsement process by submitting the complete endorsement application to the endorsing agency.

5. Letter of Endorsement

When a provider is determined to have met all the endorsement requirements, the endorsing agency shall send, via trackable mail, the standard agreement to the provider for signature within 10 calendar days of the successful completion of the onsite review. The standard agreement can be accessed on the DMH/DD/SAS website at www.ncdhhs.gov/mhddsas. The provider shall return the signed standard agreement to the endorsing agency within 15 calendar days of receipt. Evidence of adequate insurance coverage, as noted in the standard agreement, shall be submitted with the signed standard agreement.

Upon receipt of the signed standard agreement, the endorsing agency shall notify the provider of the status of its endorsement within 10 calendar days of receipt of the signed standard agreement, utilizing the standard Notification of Endorsement Action (NEA) letter; a copy of the NEA letter shall be sent to the DMH/DD/SAS, Accountability Team, via electronic submission at endorsements.accountability@dhhs.nc.gov. The letter must indicate the beginning and expiration date of the endorsement period.
The provider must complete the online provider enrollment application electronically and submit the supporting documentation to DMA's Provider Enrollment Section once endorsement is granted. An endorsed provider **must** be directly enrolled by DMA prior to delivering or billing for Medicaid-covered services. The provider will not be reimbursed by NC Medicaid for any services requiring endorsement that are delivered prior to the endorsement by the endorsing agency and enrollment as a provider with DMA to provide Medicaid-reimbursable mh/dd/sa services (i.e., Community Intervention Services).

Endorsement and Medicaid enrollment for services other than CAP-MR/DD is site and service specific.

6. Denial of Endorsement

A provider's application for endorsement shall be denied for any of the following reasons:

(a) The provider fails to comply with endorsement requirements;
(b) The provider does not meet the requirements identified in clinical policy specific to the service definition;
(c) The provider fails to meet all applicable requirements of Medicaid policy and regulations, federal and state licensure and certification requirements for the type of service for which application was made;
(d) The provider has relationships with excluded/debarred individuals or entities. An endorsement application shall be denied if a person with an ownership or control interest or managing employee as those terms are defined in federal regulation, including but not limited to a medical director or supervising physician, is excluded from Medicaid participation in other federal health care programs or debarred from federal procurement. A denial may be reversed if the provider submits documentation that the relationship with the excluded or debarred individual or entity has been terminated within 30 calendar days of the notice of denial.
(e) The provider entity or any of its owners have felony convictions determined by the endorsing agency to be detrimental to the best interests of the program or the provider has been convicted of a crime specified in G. S. 122C -80. A denial may be reversed if the provider submits documentation that the relationship with the convicted individual has been terminated within 30 calendar days of the notice of denial;

(f) The information provided during the application process was false or misleading;
(g) At the time of the scheduled clinical interview, the provider has not hired all staff members to meet the staffing requirements of the service definition;
(h) On the basis of the clinical interview, the provider does not meet clinical interview requirements;
(i) On the basis of the onsite review, it is determined that the provider is not equipped to provide services for which application was made;
(j) The applicant does not have a physical address where services can be provided, does not have a place where client records can be stored in accordance with HIPAA requirements or does not meet other requirements necessary to do business; or
(k) The applicant has not obtained the required state and local licenses, permits or authorization including, but not limited to, professional and facility licenses to perform the services it intends to provide.

The provider shall be notified that endorsement has been denied via the standard NEA letter. The basis for the denial of endorsement noted on the NEA letter shall be consistent with the reasons noted in this policy. The notice/letter shall be signed by the endorsing agency's Chief Executive Officer (CEO) or appointed designee with a copy submitted to the DMH/DD/SAS Accountability Team.

7. Withdrawal of Endorsement

Withdrawal of endorsement may be initiated by the endorsing agency, DMH/DD/SAS, the Secretary of DHHS, or the endorsed provider organization. There are two types of endorsement withdrawals: voluntary and involuntary.

A voluntary withdrawal of endorsement shall be initiated by the endorsed provider. A provider's endorsement may be voluntarily withdrawn if the provider is in **"Good Standing"** with the endorsing agency at the time of the request. The provider must submit a written request, signed by its Chief Executive Officer or Chief Operating Officer, stating the reason for the withdrawal and agreement to the voluntary withdrawal of endorsement.

If the endorsed provider is voluntarily withdrawing endorsement of only one service and will continue to maintain endorsement for other services, the endorsing agency shall amend the standard agreement and issue the NEA letter reflecting that change to the provider. A provider that voluntarily withdraws its endorsement may reapply for service endorsement with any endorsing agency at any time.

Involuntary withdrawal of endorsement shall be initiated by the endorsing agency for any of the following reasons:

(a) The provider is no longer compliant with endorsement requirements;
(b) The provider no longer meets the requirements identified in clinical policy specific to the service definition;
(c) The provider has not accepted consumers or delivered services to consumers within 60 calendar days from the date of the DMA enrollment letter.
(d) The provider fails to serve consumers during any consecutive 120 day period;
(e) The provider does not meet federal and state Medicaid statutes, rules, regulations or DHHS policies, guidelines, manuals, Medicaid Bulletins or Implementation Updates, or

federal and state licensure and certification requirements for the type of service the provider agency is endorsed to deliver;

(f) The provider submitted false, misleading or substantially inaccurate information in its application for business entity verification or site/service endorsement;
(g) The provider fails to achieve National Accreditation pursuant to NCGS § 122C – 81;
(h) The provider's National Accreditation status lapses or is withdrawn;
(i) The provider's licensure is not current;
(j) The provider fails to comply with any provisions of the standard agreement including, but not limited to, failure to maintain insurance coverage;
(k) The provider fails to meet other conditions of participation set forth by DMA;
(l) The provider fails to comply with any of the following as noted in NCGS § 122C-115.4(b)(2)
    - Meet defined quality criteria.
    - Adequately document the provision of services.
    - Provide required staff training.
    - Provide required data to the LME.
    - Allow the LME access in accordance with rules established under G.S. 143B-139.1.
    - Allow the LME access in the event of an emergency or in response to a complaint related to the health or safety of a client; or
(m) There is evidence of substantial failure to comply with current rules or NC General Statutes which apply to the provider agency or the endorsed service.

If the provider's endorsement is involuntarily withdrawn for any of the reasons listed above, the provider's standard agreement shall be withdrawn by the endorsing agency and all other endorsing agencies will be notified if applicable.

The endorsing agency shall notify the provider of the intent to withdraw endorsement via the standard NEA letter. The basis for the withdrawal of endorsement noted on the NEA letter shall be consistent with the reasons noted in this policy. The notice/letter shall be signed by the endorsing agency CEO or appointed designee.

Once the provider's appeal rights with the LME and the DMH/DD/SA Appeals Panel have been exhausted or the timeframe for request of local reconsideration has expired, the endorsing agency shall issue the following notifications about the withdrawal of the provider's endorsement:

(a) a copy of the notice/letter shall be electronically submitted to DMH/DD/SAS, Accountability Team at endorsements.accountability@dhhs.nc.gov;
(b) a copy of the notice/letter shall be electronically submitted to DMA at endorsement.dma@lists.ncmail.net;
(c) a copy of the notice/letter shall also be mailed to the Chief of Mental Health and Certification Section at Division of Health Service Regulation (DHSR) if it is a service subject to DHSR licensure. The mailing address is 2718 Mail Service Center, Raleigh, NC 27699-2718; and
(d) notification to other LMEs statewide of the withdrawal of endorsement.

The notifications should also include (if known) whether the provider is appealing the endorsing agency's decision to OAH. If the endorsing agency is withdrawing endorsement of only one service and the provider will continue to maintain endorsement for other services, the endorsing agency shall amend the standard agreement and issue the NEA letter to the provider.

Withdrawal of business entity verification shall result in withdrawal of all of the provider's existing site/service specific endorsements and shall preclude the provider agency from being endorsed or enrolled for any mh/dd/sa Medicaid reimbursable service. In the case of a withdrawal of business entity verification, the endorsing agency shall notify DMA prior to the effective date of the withdrawal so that DHHS can determine any other site/service specific endorsements which are affected by the withdrawal of the business entity verification. The endorsing agency shall notify other LME(s) statewide of the withdrawal of business entity verification.

If the provider's business entity verification has been involuntarily withdrawn, the provider must wait 12 months to request business entity verification from **any** endorsing agency. If a site/service endorsement is involuntarily withdrawn, there shall be a 12 month waiting period before the provider can reapply for site/service endorsement for that service with that specific endorsing agency.

In the event of the withdrawal of endorsement, the LME is responsible for ensuring that the provider immediately and adequately transitions existing consumers to an endorsed provider per the consumer's choice. Consumers shall be provided with the LME's Customer Service contact information in the event support is needed by the consumer during the transition Failure to immediately and appropriately transition existing consumers shall result in the withdrawal of the provider's business verification. The provider shall not accept any new admissions or referrals during the transition period. For any directly enrolled NC Medicaid Provider who appeals the involuntary withdrawal of an endorsement, or an endorsement that was not renewed by the endorsing agency; any services provided after the date that the withdrawal of endorsement was upheld by the DMH/DD/SAS Appeals Panel shall be subject to recoupment by DMA. Services shall not be provided or reimbursed by NC Medicaid during the pendency of any appeal to either the Office of Administrative Hearings or any state or federal courts.

All providers, including those whose endorsement was voluntarily or involuntarily withdrawn, are responsible for maintaining and safeguarding all the service records and financial records as outlined in the Records Management and Documentation Manual for Providers of Publicly-Funded MH/DD/SA Services, CAP-MR/DD Services, and Local Management Entities [APSM 45-2], and in accordance with the requirements of the DHHS Records Retention and Disposition Schedule for Grants and the Records Retention and Disposition Schedule for State and Area Facilities, Division Publication, APSM 10-3.

8. Standard Agreement and LME Operations Manual

The endorsing agency shall enter into a standard agreement (i.e., MOA) with an endorsed provider organization. The standard agreement and Operations Manual contain the information and materials, such as uniform forms, provisions and statewide requirements for all endorsed Medicaid providers. The Operations Manual is available at http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/forms/operationsmanual4-22-05template.pdf

9. Reconsideration and Appeal Rights of the Provider

A provider whose business entity verification and/or service endorsement status is denied or involuntarily withdrawn by an endorsing agency must first request a local reconsideration of the decision by the endorsing agency prior to filing an appeal to the State MH/DD/SA Appeals Panel. If the endorsing agency upholds the decision to withdraw endorsement, the provider must first request an appeal from the State MH/DD/SA Appeals Panel before filing a petition for contested case hearing with the Office of Administrative Hearings pursuant to Chapter 150B of the General Statutes.

The provider shall file an appeal to the State MH/DD/SA Appeals Panel by forwarding the final decision of the endorsing agency, along with all supplementary and supporting documentation considered during the local appeals process, to the Director of the NC DMH/DD/SAS within 15 calendar days of the local reconsideration decision being rendered, per 10A NCAC 27G. 0810. A provider's appeal rights are set forth in G. S. 122C-151.4 and in administrative rules 10A NCAC 27G .0810 - .0812.

The endorsing agency shall inform the provider in writing, of all appeal rights at the local and state level and the required filing time frames. If a provider fails to appeal the endorsing agency's decision within the required time frames, the endorsing agency decision to deny or withdraw the endorsement stands and is considered final.

10. Endorsement of Providers within Forty Miles of North Carolina

A provider seeking enrollment in the North Carolina Medicaid program as an In-State or Border Provider of mh/dd/sa services to consumers from North Carolina, (i.e., those providers whose physical location is within the limits established by the DMA for treating an out-of-state provider as in-state for the purposes of Medicaid billing), shall complete an In State/Border provider application and meet the requirements for endorsement as set forth in this policy.

An out-of-state provider shall apply for endorsement with an endorsing agency per the stated policy. The endorsing agency shall be an LME whose catchment area is contiguous with the county or catchment area of the out-of-state provider, or one that has a consumer that has selected the out-of-state provider as his or her choice of provider.

A provider applying for endorsement of a service that would require facility licensure if the provider were located in North Carolina, must meet the health, safety and building requirements established for providers of an equivalent service in the state in which the provider is located. The endorsing agency shall contact the oversight agencies in the state the provider is located to determine if the provider meets the requirements.

11. Service Endorsement CAP-MR/DD

- Endorsement for CAP-MR/DD services is **not** site and service specific. Service endorsement is statewide therefore a provider is reviewed only once per service.

- If a currently enrolled CAP-MR/DD provider wishes to add a new waiver service to their

enrollment they must be reviewed against the service definition check sheet and complete the endorsement and DMA enrollment process for adding a new service. For any unlicensed Alternative Family Living Home (AFL), a health and safety review using the check sheet developed by the DMH/DD/SAS must be completed in lieu of a license.

- When a CAP-MR/DD provider adds a location and not a new service (a new catchment area for a service already endorsed), the provider must sign the MOA with the LME in the new catchment area.

- There is no requirement that a provider establish a site in every LME catchment area, however, it is expected that supervision and oversight is available in reasonable proximity to where services are delivered**.**

- Any time an enrolled Residential Support provider desires to open a new AFL site the provider must notify the LME of the AFL site and the LME must complete a health and safety review for that particular home. It is not required that the already enrolled provider be reviewed against the Residential Supports check sheet again for that AFL site. The check sheet is a requirement only for a provider who has never been endorsed to provide Residential Supports.

- Although Enhanced Personal Care and Enhanced Respite have distinct billing codes they are **not** separate services that require endorsement. A provider enrolled to provide Personal Care and Respite is also enrolled to provide the enhanced level of these services.

12. Service Endorsement Process for CABHA Certified Agencies

12A. CABHA certified agencies seeking endorsement for a new service (not yet endorsed to deliver)

A CABHA certified agency seeking endorsement for a new service for which it is not yet endorsed to deliver that is related to their approved service continuum (adult mental health, child mental health, adult substance abuse or child substance abuse) must follow the endorsement process as outlined in this policy with the exception of the desk review and clinical interview. The CABHA certified agency seeking endorsement for a new service that relates to their approved service continuum (adult mental health, child mental health, adult substance abuse or child substance abuse), shall only be required to complete the onsite review stage of service endorsement. The endorsing agency shall conduct the onsite review within 20 calendar days of the receipt of the endorsement application. The agency shall hire all staff members to meet the staffing requirements of the service for which the agency is seeking to become newly endorsed by the date of the onsite review.

A CABHA certified agency seeking endorsement for a new service for which it is not yet endorsed to deliver that is **not** related to their approved service continuum (e.g. approved service continuum is child mental health and provider is seeking endorsement for Assertive Community Treatment Team) must follow the endorsement process as outlined in this policy with the exception of the desk review. The CABHA certified agency seeking endorsement for a new service that does not relate to their approved service continuum, shall be required to complete the clinical interview and onsite review stages of service endorsement. The endorsing agency shall conduct the clinical interview within 20 calendar days of the receipt of the endorsement application. The agency shall hire all staff members to meet the staffing

requirements of the service for which the agency is seeking to become newly endorsed by the date of the clinical interview.

In both instances, the CABHA certified agency shall notify the LME of its receipt of the DMA enrollment letter within 10 calendar days from the date of the DMA enrollment letter via trackable mail. The LME shall conduct a monitoring visit within 60 calendar days from the date of the DMA enrollment letter. This monitoring shall include a review of compliance with the service definitions and sources of evidence indicated on the standardized NC DHHS – DMH/DD/SAS Endorsement check sheet. The 60 day monitoring review shall include but not be limited to a review of documents related to the following elements:

(a) Provider requirements: provider staff training on DHHS and LME requirements for appropriate documentation, forms, prior authorizations, and continued insurance coverage per the Standard Agreement;
(b) Staff requirements: complete listing of all staff names, qualifications, and positions (note that all staff required for a service per the service definition are required to be employed and providing the service) to ensure staff are fully trained on the goals and objectives of the service and the strategies and techniques used, Medicaid RA Forms, Paid claims, ensure staff meet training requirements per definition;
(c) Service type/setting requirements: review service notes to ensure services provided are appropriate to consumer's needs based on diagnosis, person centered plan, Medicaid RAs, etc.;
(d) Clinical requirements: clinical reviews, staff supervision provided, staff interviews; and
(e) Documentation requirements: compliance with Basic Medicaid Billing guide and Medicaid provider enrollment agreement; all documentation must support the legitimacy of billing including a review of paid claims to determine if billing is supported by service notes.

The CABHA certified agency is required to be delivering the newly endorsed service within 60 calendar days from the date of the DMA enrollment letter. If the CABHA certified agency has not accepted consumers and delivered the newly endorsed service within 60 calendar days from the date of the DMA enrollment letter, endorsement for that service shall be involuntarily withdrawn.

12B. A CABHA certified agency currently endorsed and enrolled to provide a service seeking to expand by delivering the same service at a new site not yet endorsed or seeking to expand by adding the same service at a currently endorsed site

A CABHA certified agency currently endorsed and enrolled to provide a service and wishes to expand by delivering the **same** service at a new site and that site location has not been endorsed; or wishes to expand by adding the **same** service at a currently endorsed site must follow the endorsement process as outlined in this policy with the exception of the desk review, clinical interview and onsite review. Instead, the CABHA certified agency shall submit a letter of attestation attesting compliance to the service definition along with supporting documentation to the LME in the catchment area where the new site will be located; or to the LME in the catchment area where the currently endorsed site is located and the service (currently endorsed and enrolled to deliver) will be added. The letter of attestation along with evidence of adequate insurance, tax ID number, NPI number and a current facility license (as applicable) shall be sent to the LME via trackable mail. Upon receipt of the letter of attestation and supporting documentation, the

LME shall review it for completeness. The LME **shall not** complete a desk review, clinical interview or onsite review.

The LME shall update the standard agreement (MOA) or send the provider the standard agreement (MOA) for signature as applicable within 5 calendar days of receipt of the letter of attestation and supporting documentation. The LME shall send the NEA granting endorsement to the CABHA certified agency within 5 calendar days of updating the standard agreement (MOA) or receipt of the signed standard agreement (MOA) as applicable.

The LME shall send a copy of the NEA letter to the DMH/DD/SAS, Accountability Team, via electronic submission at endorsements.accountability@dhhs.nc.gov. The letter must indicate the beginning and expiration date of the endorsement period. Upon receipt of the signed NEA, the CABHA certified agency shall complete the applicable online DMA provider enrollment application electronically and submit the supporting documentation to DMA's Provider Enrollment Section.

The CABHA certified agency shall notify the LME who reviewed the attestation letter and issued the NEA, of its receipt of the DMA enrollment letter within 10 calendar days from the date of the DMA enrollment letter via trackable mail. The LME shall conduct a monitoring visit within 60 calendar days from the date of the DMA enrollment letter. This monitoring shall include a review of compliance with the service definitions and sources of evidence indicated on the standardized NC DHHS-DMH/DD/SAS Endorsement check sheet. The 60 day monitoring review shall include but not be limited to a review of documents related to the following elements:

(a) Provider requirements: provider staff training on DHHS and LME requirements for appropriate documentation, forms, prior authorizations, and continued insurance coverage per the Standard Agreement;
(b) Staff requirements: complete listing of all staff names, qualifications, and positions (note that all staff required for a service per the service definition are required to be employed and providing the service) to ensure staff are fully trained on the goals and objectives of the service and the strategies and techniques used, Medicaid RA Forms, Paid claims, ensure staff meet training requirements per definition;
(c) Service type/setting requirements: review service notes to ensure services provided are appropriate to consumer's needs based on diagnosis, person centered plan, Medicaid RAs, etc.;
(d) Clinical requirements: clinical reviews, staff supervision provided, staff interviews; and
(e) Documentation requirements: compliance with Basic Medicaid Billing guide and Medicaid provider enrollment agreement; all documentation must support the legitimacy of billing including a review of paid claims to determine if billing is supported by service notes.

The CABHA certified agency is required to be delivering the service within 60 calendar days from the date of the DMA enrollment letter. If a CABHA certified agency has not accepted consumers and delivered the service to consumers within 60 calendar days from the date of the DMA enrollment letter, endorsement shall be withdrawn.

13. Process for LME Endorsement

An LME that wishes to provide and seek reimbursement for Medicaid Community Intervention Services must follow the endorsement process as stated in this policy. In addition, the LME must submit a written request and receive a waiver approval from DHHS to provide direct services. LMEs will only be considered for a waiver to provide direct services(s) if there is evidence that community capacity is inadequate in the catchment areas for that given service and the LME is working aggressively to recruit and maintain adequate provider capacity. An LME plan indicating service needs, gaps, and possible strategies to assure adequate community capacity will be considered as evidence.

The LME must be directly enrolled with the DMA and is subject to the endorsement process by DHHS. The DMH/DD/SAS shall review applications and conduct the desk review, clinical interview and onsite reviews of LME services for endorsement. Endorsement reviews shall be performed by a two member team of the DMH/DD/SAS staff. The timeframes for the LME endorsement process are the same as the timeframes stated in this policy for provider endorsement.

LME endorsement will only be granted on a temporary basis, as specified in the LME waiver. Prior to the expiration of the waiver, the LME must request an extension to the waiver to continue to provide the service. The request must include a justification to continue providing the service along with a brief description of attempts to build community capacity. The letter shall be submitted to the DMH/DD/SAS LME Systems Performance Team Leader.

The Secretary of DHHS, or his or her designee, shall make the final decision regarding waiver approvals and time frames of approvals.

14. Business Entity Verification Renewal

Business entity verification status is valid for up to three years. In order to renew a provider's business entity verification, the provider shall submit to the endorsing agency that granted the provider's business entity verification; a copy of the National Accreditation Certificate, a standardized Business Entity Renewal Letter of Attestation that includes the current business information (i.e., name, business status, and address), and a report of any dissolutions, revocations, or revenue suspensions that have occurred over the past three years. In addition, the provider shall submit evidence of good standing with the U.S. or the North Carolina Departments of Revenue.

The provider shall submit the above mentioned information at least 30 calendar days prior to the expiration of the current business entity verification via trackable mail. The endorsing agency shall review the information submitted as well as any adverse actions and sanction activity involving the provider within 10 calendar days of the receipt of the Business Entity Renewal Letter of Attestation. The endorsing agency has the authority and the discretion to conduct an onsite review(s) based upon the information contained in the standardized Business Entity Renewal Letter of Attestation.

If the information submitted meets business verification requirements, the LME shall complete a NEA letter indicating the new effective business verification dates and send the updated NEA to the provider via trackable mail. The provider will be responsible for submitting the updated NEA to DMA.

A provider that fails to submit the standardized Business Entity Renewal Letter of Attestation prior to the business verification expiration date or that provides false or misleading information on the standardized Business Entity Renewal Letter of Attestation to the endorsing agency shall have its business entity verification involuntarily withdrawn. The endorsing agency shall notify the provider via an NEA sent via trackable mail that the business entity verification was involuntarily withdrawn because of failure to submit the Business Entity Renewal Letter of Attestation and/or because false or misleading information was submitted. The endorsing agency shall also notify DMA and DMH/DD/SAS via an NEA letter that the business entity verification has expired and has not been renewed because of the provider's failure to submit the Business Entity Renewal Letter of Attestation and/or because the provider submitted false or misleading information in the Business Entity Renewal Letter of Attestation.

The provider must notify the endorsing agency immediately if at any time the provider's national accreditation status lapses or is withdrawn. The provider's endorsement shall be involuntarily withdrawn, in the event the provider fails to notify the endorsing agency that the accreditation status has lapsed or has been withdrawn. Loss of national accreditation for the affiliated business entity shall lead to withdrawal of endorsement for mh/dd/sa services that require accreditation.

15. Service Re-endorsement

Service endorsement is valid for up to three years. It is the responsibility of the endorsing agency to initiate the service re-endorsement process. The LME shall make a determination regarding compliance with service specific requirements for currently endorsed providers. Compliance determination should be as a result of monitoring activities or onsite reviews (monitoring reviews, post payment reviews, POC reviews, etc.) that were completed during the three year endorsement time period. The LME shall make the determination as to the need for an onsite review. An onsite review is not required.

Providers currently under an **approved** plan of correction may not be denied re-endorsement for that reason. If approved for re-endorsement, the LME shall renew the standard MOA and complete the NEA letter indicating an endorsement period of three additional years. The provider will be responsible for submitting the NEA to DMA.

If re-endorsement is denied the LME will indicate "denial" on the comment section and include the reason. The LME will take the following actions:

(a) Send a copy of the NEA to the provider via trackable mail
(b) Notify other LMEs statewide
(c) Submit the NEA to DMA via electronic submission